State: *Arkansas* ***Filing Company:*** *American General Life Insurance Company*
TOI/Sub-TOI: *L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name: *SIT APP*
Project Name/Number: */*

Filing at a Glance

Company:	American General Life Insurance Company
Product Name:	SIT APP
State:	Arkansas
TOI:	L04I Individual Life - Term
Sub-TOI:	L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Filing Type:	Form
Date Submitted:	08/21/2012
SERFF Tr Num:	AMGN-128652008
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	SIT APP
Implementation Date Requested:	On Approval
Author(s):	Luis Cardozo
Reviewer(s):	Linda Bird (primary)
Disposition Date:	08/27/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** American General Life Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: SIT APP
Project Name/Number: /

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Luis Cardozo

Status of Filing in Domicile: Authorized
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 08/27/2012
State Status Changed: 08/27/2012
Created By: Luis Cardozo
Corresponding Filing Tracking Number: SIT APP

Filing Description:

Re: American General Life Insurance Company
AGLC-106220-2012 Individual Term Life Insurance Application

Dear Sir or Madam:

American General Life Insurance Company submits form AGLC-106220-2012 Individual Term Life Insurance Application for approval. It is a new application form and does not replace any previously filed form.

Form AGLC-106220-2012 is a simplified issue application for additional individual term insurance, used in direct marketing to our existing policy holders. There is no agent involved in the process. The offer is mailed to the proposed insured on an accept/reject basis. Any “yes” answer to the questions will automatically reject the applicant. The exception to automatic rejection will be in cases where the applicant responds affirmatively to the “existing or pending annuity or life insurance” question.

The application will be used with policy form 07900 (approved on 11-17-06).

The form is in its final printed form. We have attached a Statement of Variability to explain the variable items. Unless otherwise informed, we reserve the right to alter the layout of the enclosed forms, including sequential ordering of the questions, provisions, and type font, size (but not less than 10 point) and color.

Should there be any further question or requirements please contact me at 800-247-8837 extension 831-2465 or by e-mail at luis.cardozo@aglife.com.

Company and Contact

Filing Contact Information

Luis Cardozo,
2929 Allen Parkway
Mail Stop A9-90
Houston, TX 77019

luis.cardozo@aglife.com
713-831-2465 [Phone]
713-342-7550 [FAX]

State: *Arkansas* ***Filing Company:*** *American General Life Insurance Company*
TOI/Sub-TOI: *L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name: *SIT APP*
Project Name/Number: */*

Filing Company Information

American General Life Insurance Company
2727-A Allen Parkway
Houston, TX 77019
(713) 831-3508 ext. [Phone]

CoCode: 60488
Group Code: 12
Group Name: AIG
FEIN Number: 25-0598210

State of Domicile: Texas
Company Type:
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? Yes
Fee Explanation:
Per Company: No

Company	Amount	Date Processed	Transaction #
American General Life Insurance Company	$50.00	08/21/2012	61861062

SERFF Tracking #:	*AMGN-128652008*	***State Tracking #:***		***Company Tracking #:***	*SIT APP*

State:	*Arkansas*	***Filing Company:***	*American General Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*		
Product Name:	*SIT APP*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/27/2012	08/27/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	individual Life term insurance application	Luis Cardozo	08/23/2012	08/23/2012

SERFF Tracking #:	*AMGN-128652008*	***State Tracking #:***		***Company Tracking #:***	*SIT APP*

State:	*Arkansas*	***Filing Company:***	*American General Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*		
Product Name:	*SIT APP*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/27/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statement of Variability		Yes
Form (revised)	individual Life term insurance application		Yes
Form	individual Life term insurance application	Replaced	Yes

SERFF Tracking #:	*AMGN-128652008*	***State Tracking #:***		***Company Tracking #:***	*SIT APP*

State:	*Arkansas*	***Filing Company:***	*American General Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*		
Product Name:	*SIT APP*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 08/23/2012

Comments:

The form number has been revised to: AGLC106220-2012

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AGLC106220-2012	Application/Enrollment Form	individual Life term insurance application	Initial				50.000	SIT APP v20 GEN STATE FILING.pdf

SERFF Tracking #:	*AMGN-128652008*	***State Tracking #:***		***Company Tracking #:***	*SIT APP*

State:	*Arkansas*	***Filing Company:***	*American General Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*		
Product Name:	*SIT APP*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: AGLC-106220--2012

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		AGLC106220-2012	AEF	individual Life term insurance application	Initial:	50.000	SIT APP v20 GEN STATE FILING.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

American General Life Insurance Company
2727-A Allen Parkway, Houston, Texas 77019

INDIVIDUAL TERM LIFE INSURANCE APPLICATION FORM

Proposed Insured and Owner: [John Doe]
Address: [123 Any St.]
[Anytown, US 12345]

Reference Policy No. [123456789]

[**Phone** 555-1212] [**Email** Johndoe@aol.com]

Beneficiary: Please print the name of your beneficiary here:

☑ **Primary Beneficiary**

Height 6 ft 0 in **Weight** 150 lbs

Name Jane Doe [Address 123 Any Street, AT, US] Relationship: wife

[SSN 123-45-6789] Date of Birth 1 / 1 /50 Email janedoe@aol.com Phone # 555-1212]

❑ **Primary** ❑ **Contingent Beneficiary**

Name _____ [Address _____] Relationship: _____

[SSN _____ Date of Birth ___/___/___ Email _____ Phone # _____]

I wish to apply for [$25,000] of [15] year Term Life Insurance issued by American General Life Insurance Company ("Company"). I understand that the premium for this coverage is [$25.00/month].

Qualifying Medical Questions:

1. In the past five years, has a licensed health care professional diagnosed you with or treated you for any of the conditions listed below:..... ❑Yes ☑No
   a. Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis?
   b. Chronic liver disease, hepatitis, cirrhosis of the liver, or chronic kidney disease (not including kidney stones)?
   c. Heart attack (myocardial infarction), coronary artery or heart disease, congestive heart failure, heart valve disease, arrhythmia, arteriosclerosis, atherosclerosis, enlarged heart or embolism (blood clots)?
   d. Sleep apnea, or do you currently use a continuous positive airway pressure (CPAP) machine or supplemental oxygen?
   e. Stroke, transient ischemic attack (TIA), disease of the heart or blood vessels, dementia or Alzheimer's disease?
   f. Diabetes mellitus or high blood sugar; ulcerative colitis, Crohn's disease (ileitis or regional enteritis), systemic lupus erythematosis, or scleroderma?
   g. AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus) or other immune system disease?
   h. Alcohol, drug, or substance abuse, or has such treatment been recommended; Mental or nervous system disorder for which inpatient treatment or confinement in an inpatient or residential facility was recommended or completed; Major Depression, or bipolar disorder (manic depression)?
2. In the past five years has a licensed health care professional recommended that you have any tests that have not yet been performed, except those tests related to the Human Immunodeficiency Virus (AIDS virus); such as chest x-ray, stress electrocardiogram, echocardiogram, stress echocardiogram, colonoscopy, cardiac catheterization, blood test or biopsy?..... ❑Yes ☑No
3. In the past five years, has a licensed health care professional diagnosed you with or treated you for any cancer of the internal organs or blood or melanoma?..... ❑Yes ☑No
4. Has a physician or licensed health care professional recommended or scheduled you for surgery that has not been performed?..... ❑Yes ☑No
5. In the past 12 months, have you smoked or used tobacco or nicotine products in any form... ❑Yes ☑No

Non-Medical Questions:

1. Within the next two years, will you reside outside of the US or Canada, or will you travel outside of the US or Canada for more than nine weeks?..... ❑Yes ☑No
2. In the past five years, have you participated in, or in the next two years, do you intend to participate in: any flights as a trainee, pilot or crew member, scuba diving, skydiving or parachuting, ultra light aviation, auto racing, cave exploration, hang gliding, boat racing, or mountaineering?..... ❑Yes ☑No
3. In the past five years, have you plead guilty or been convicted of driving under the influence of alcohol or drugs or had more than two driving violations?..... ❑Yes ☑No
4. In the past five years have you been convicted of, or pled guilty or no contest to a felony, or do you have any such charge pending against you?..... ❑Yes ☑No

Sign on reverse

Replacement Question:

Do you have any existing or pending[1] annuity or life insurance contracts?..... ☑Yes ❑No

If yes, do you intend to replace[2] the existing insurance with the insurance being applied for?..... ❑Yes ☑No

-If you do intend to replace[2] the existing insurance, please provide the following information:

Policy Number _____Insurance Company _____

Policy Number _____Insurance Company _____

[1] Policy pending under a binding or conditional receipt; [2]Replace means that the insurance being applied for may replace, change or use monetary value from an existing or pending annuity or life insurance policy.

Authorization and Signatures

I agree that all statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief. I understand this application shall be the basis for and become part of any policy issued; and that the Company will rely on the statements and answers when making its decision to issue a policy. I understand that any false or incomplete statements or answers may void coverage. I understand that any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while I am alive. I further understand that all statements and answers in all parts of this application must continue to be true and complete; and that I must notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is issued. I have also read and understand the disclosures provided.

I give my consent to any consumer reporting agency or insurance support organization and the MIB to give the Company information related to: my medical consultations; treatments; hospital confinements; drug or alcohol use; prescriptions; motor vehicle records from the Department of Motor Vehicles; or any other information about me. I understand that the information obtained will be used to determine insurance eligibility, as well as eligibility for benefits and contestability of the policy issued.

I also authorize the Company to start electronic debits for the payment of premiums and to continue such debits against the bank account at the financial institution [previously given to the Company for the payment of premiums on the referenced policy]. I certify that I am a signatory on the account. I understand that: 1) a payment is not deemed made until the Company receives the actual payment; and 2) I am liable to the Company for the dishonor of any debit and the related costs. This payment authorization may be terminated by me or the Company at any time for any reason. Written notice of such termination must be given to the non-terminating party. Such notice to the Company is not effective until the Company has a fair amount of time to act on it.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

John Doe
Proposed Insured and Owner Signature

[Anytown, US]
City, State

7/ 20/2012
Date

Health Insurance Portability and Accountability Act ("HIPAA")

The purpose of this authorization is to seek your permission to access information that will be used in the underwriting of your policy. American General Life Insurance Company and its representatives (referred to as the "Company", "we", "us" or "our") are subject to federal privacy laws and any information released to us will be used and disclosed as described in our Privacy Policy. However, upon our disclosure the information may no longer be protected by federal privacy rules.

This authorization is voluntary; however, if you do not provide it, we may not be able to obtain the medical information necessary to consider your application. This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. You are entitled to receive a copy. Please read and sign below.

I authorize health care providers and facilities, pharmacies or pharmacy benefit managers, any insurance or reinsurance company, any consumer reporting agency or insurance support organization, and the Medical Information Bureau (MIB) to give the Company any information relating to my health (except psychotherapy notes) and my insurance policies and claims. This information may include: information relating to any medical consultation or treatments, hospital confinements, drug or alcohol use, prescriptions, diseases including HIV or AIDS, and other information about me such as my name and address.

The information obtained will be used to determine insurance eligibility, as well as eligibility for benefits and contestability of the policy issued. Any information gathered during the evaluation of my application may be disclosed to: reinsurers, MIB, or other persons or organizations performing services; including me; my physician; anyone required by law to receive such information; or to detect health care fraud.

I understand that I can revoke this authorization at any time by sending a written request to the Company. This revocation will not apply to uses and disclosures of my information by the Company for underwriting, claims administration and other uses associated with the application or policy administration. This revocation will not apply to the extent the Company relied on the authorization, or, the law allows the Company to contest a claim or the policy itself.

John Doe
Proposed Insured and Owner Signature

[Anytown, US]
City, State

7/ 20/2012
Date

SERFF Tracking #:	*AMGN-128652008*	***State Tracking #:***	***Company Tracking #:*** *SIT APP*

State:	*Arkansas*	***Filing Company:***	*American General Life Insurance Company*
TOI/Sub-TOI:	*L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*		
Product Name:	*SIT APP*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Read AGLC-SITAPP.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
SITAPP-SOV-AGLC.pdf			

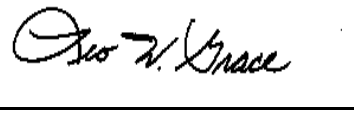
READABILITY
CERTIFICATION

Flesch score

American General Life Insurance Company,

This is to certify that the attached Form No(s). AGLC-106220-2012

Has achieved Flesch Reading Score of 50 and complies with the readability requirements regulation.



Leo W. Grace
Vice President, Product Development

8-21-2012
Date

American General Life Insurance Company
Statement of Variability

AGLC-106220-2012

Individual Term Life Insurance Application

The following bracketed items are variable as indicated:

The **John Doe** information and **Reference Policy No**. will be pre-populated.

The fields for the Proposed Insured and Owner: **Phone** and **Email** will print out only in cases where the information is required.

The following blank fields for **Primary** and **Contingent Beneficiary** will print only in the states that require the information of the beneficiaries from the applicant. In states where obtaining this information is not required that area will be a blank space.

- **Address**
- **SSN**
- **Date of Birth**
- **Email**
- **Phone** #

The (1) coverage amount applied for, (2) term duration, (3) premium amount and the (4) billing mode are shown in the sentence below:

> "I wish to apply for (1) [$25,000] of (2) [15] year Term Life Insurance issued by American General Life Insurance Company ("Company"). I understand that the premium for this coverage is [(3) $25.00/ (4) month]."

(1) The coverage amount range is**:** $25,000 – $250,000.

(2) The available term durations**:** 10 year, 15 year thru 30 year term plans.

(3) Premium for the coverage applied for.

(4) Billing modes – Monthly, quarterly, semi-annually or annually.

Authorization and Signatures
The wording below will replace the bracketed section in the third paragraph in those instances where the authorization for electronic debits involves a voided check, see VOID check image that will appear next to text.

> "indicated on the attached voided check. "

The signature line for the **city and state** will be pre-populated.

Superceded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/21/2012	Form	individual Life term insurance application	08/23/2012	SIT APP v20 GEN STATE FILING.pdf (Superceded)

American General Life Insurance Company
2727-A Allen Parkway, Houston, Texas 77019

INDIVIDUAL TERM LIFE INSURANCE APPLICATION FORM

Proposed Insured and Owner: [John Doe]
Address: [123 Any St.]
[Anytown, US 12345]

Reference Policy No. [123456789]

[**Phone** 555-1212] [**Email** Johndoe@aol.com]

Beneficiary: Please print the name of your beneficiary here:

☑ **Primary Beneficiary**

Height 6 ft 0 in **Weight** 150 lbs

Name Jane Doe [Address 123 Any Street, AT, US] Relationship: wife

[SSN 123-45-6789] Date of Birth 1 / 1 /50 Email janedoe@aol.com Phone # 555-1212]

❑ **Primary** ❑ **Contingent Beneficiary**

Name _____ [Address _____] Relationship: _____

[SSN _____ Date of Birth ___/___/___ Email _____ Phone # _____]

I wish to apply for [$25,000] of [15] year Term Life Insurance issued by American General Life Insurance Company ("Company"). I understand that the premium for this coverage is [$25.00/month].

Qualifying Medical Questions:

1. In the past five years, has a licensed health care professional diagnosed you with or treated you for any of the conditions listed below:..... ❑Yes ☑No
   a. Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis?
   b. Chronic liver disease, hepatitis, cirrhosis of the liver, or chronic kidney disease (not including kidney stones)?
   c. Heart attack (myocardial infarction), coronary artery or heart disease, congestive heart failure, heart valve disease, arrhythmia, arteriosclerosis, atherosclerosis, enlarged heart or embolism (blood clots)?
   d. Sleep apnea, or do you currently use a continuous positive airway pressure (CPAP) machine or supplemental oxygen?
   e. Stroke, transient ischemic attack (TIA), disease of the heart or blood vessels, dementia or Alzheimer's disease?
   f. Diabetes mellitus or high blood sugar; ulcerative colitis, Crohn's disease (ileitis or regional enteritis), systemic lupus erythematosis, or scleroderma?
   g. AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus) or other immune system disease?
   h. Alcohol, drug, or substance abuse, or has such treatment been recommended; Mental or nervous system disorder for which inpatient treatment or confinement in an inpatient or residential facility was recommended or completed; Major Depression, or bipolar disorder (manic depression)?
2. In the past five years has a licensed health care professional recommended that you have any tests that have not yet been performed, except those tests related to the Human Immunodeficiency Virus (AIDS virus); such as chest x-ray, stress electrocardiogram, echocardiogram, stress echocardiogram, colonoscopy, cardiac catheterization, blood test or biopsy?..... ❑Yes ☑No
3. In the past five years, has a licensed health care professional diagnosed you with or treated you for any cancer of the internal organs or blood or melanoma?..... ❑Yes ☑No
4. Has a physician or licensed health care professional recommended or scheduled you for surgery that has not been performed?..... ❑Yes ☑No
5. In the past 12 months, have you smoked or used tobacco or nicotine products in any form... ❑Yes ☑No

Non-Medical Questions:

1. Within the next two years, will you reside outside of the US or Canada, or will you travel outside of the US or Canada for more than nine weeks?..... ❑Yes ☑No
2. In the past five years, have you participated in, or in the next two years, do you intend to participate in: any flights as a trainee, pilot or crew member, scuba diving, skydiving or parachuting, ultra light aviation, auto racing, cave exploration, hang gliding, boat racing, or mountaineering?..... ❑Yes ☑No
3. In the past five years, have you plead guilty or been convicted of driving under the influence of alcohol or drugs or had more than two driving violations?..... ❑Yes ☑No
4. In the past five years have you been convicted of, or pled guilty or no contest to a felony, or do you have any such charge pending against you?..... ❑Yes ☑No

Sign on reverse

Replacement Question:

Do you have any existing or pending[1] annuity or life insurance contracts?..... ☑Yes ❑No

If yes, do you intend to replace[2] the existing insurance with the insurance being applied for?..... ❑Yes ☑No
-If you do intend to replace[2] the existing insurance, please provide the following information:

Policy Number _____Insurance Company _____

Policy Number _____Insurance Company _____

[1] Policy pending under a binding or conditional receipt; [2]Replace means that the insurance being applied for may replace, change or use monetary value from an existing or pending annuity or life insurance policy.

Authorization and Signatures
I agree that all statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief. I understand this application shall be the basis for and become part of any policy issued; and that the Company will rely on the statements and answers when making its decision to issue a policy. I understand that any false or incomplete statements or answers may void coverage. I understand that any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while I am alive. I further understand that all statements and answers in all parts of this application must continue to be true and complete; and that I must notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is issued. I have also read and understand the disclosures provided.

I give my consent to any consumer reporting agency or insurance support organization and the MIB to give the Company information related to: my medical consultations; treatments; hospital confinements; drug or alcohol use; prescriptions; motor vehicle records from the Department of Motor Vehicles; or any other information about me. I understand that the information obtained will be used to determine insurance eligibility, as well as eligibility for benefits and contestability of the policy issued.

I also authorize the Company to start electronic debits for the payment of premiums and to continue such debits against the bank account at the financial institution [previously given to the Company for the payment of premiums on the referenced policy]. I certify that I am a signatory on the account. I understand that: 1) a payment is not deemed made until the Company receives the actual payment; and 2) I am liable to the Company for the dishonor of any debit and the related costs. This payment authorization may be terminated by me or the Company at any time for any reason. Written notice of such termination must be given to the non-terminating party. Such notice to the Company is not effective until the Company has a fair amount of time to act on it.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

John Doe
Proposed Insured and Owner Signature

[Anytown, US]
City, State

7/ 20/2012
Date

Health Insurance Portability and Accountability Act ("HIPAA")
The purpose of this authorization is to seek your permission to access information that will be used in the underwriting of your policy. American General Life Insurance Company and its representatives (referred to as the "Company", "we", "us" or "our") are subject to federal privacy laws and any information released to us will be used and disclosed as described in our Privacy Policy. However, upon our disclosure the information may no longer be protected by federal privacy rules.

This authorization is voluntary; however, if you do not provide it, we may not be able to obtain the medical information necessary to consider your application. This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. You are entitled to receive a copy. Please read and sign below.

I authorize health care providers and facilities, pharmacies or pharmacy benefit managers, any insurance or reinsurance company, any consumer reporting agency or insurance support organization, and the Medical Information Bureau (MIB) to give the Company any information relating to my health (except psychotherapy notes) and my insurance policies and claims. This information may include: information relating to any medical consultation or treatments, hospital confinements, drug or alcohol use, prescriptions, diseases including HIV or AIDS, and other information about me such as my name and address.

The information obtained will be used to determine insurance eligibility, as well as eligibility for benefits and contestability of the policy issued. Any information gathered during the evaluation of my application may be disclosed to: reinsurers, MIB, or other persons or organizations performing services; including me; my physician; anyone required by law to receive such information; or to detect health care fraud.

I understand that I can revoke this authorization at any time by sending a written request to the Company. This revocation will not apply to uses and disclosures of my information by the Company for underwriting, claims administration and other uses associated with the application or policy administration. This revocation will not apply to the extent the Company relied on the authorization, or, the law allows the Company to contest a claim or the policy itself.

John Doe
Proposed Insured and Owner Signature

[Anytown, US]
City, State

7/ 20/2012
Date